PUBLIC REPORT OF THE TARGETED MARKET CONDUCT EXAMINATION

OF THE CLAIMS PRACTICES OF THE

LIFE INSURANCE COMPANY OF NORTH AMERICA
NAIC # 65498 CDI # 1513-1

AS OF JUNE 20, 2006

STATE OF CALIFORNIA

DEPARTMENT OF INSURANCE

MARKET CONDUCT DIVISION

FIELD CLAIMS BUREAU

#23982v2

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DEPARTMENT OF INSURANCE
Consumer Services and Market Conduct Branch
Field Claims Bureau, 11th Floor
300 South Spring Street
Los Angeles, CA 90013

August 3, 2007

The Honorable Steve Poizner
Insurance Commissioner
State of California
45 Fremont Street
San Francisco, California 94105

Honorable Commissioner:

Pursuant to instructions, and under the authority granted under Part 2, Chapter 1, Article 4, Sections 730, 733, 736, and Article 6.5, Section 790.04 of the California Insurance Code; and Title 10, Chapter 5, Subchapter 7.5, Section 2695.3(a) of the California Code of Regulations, an examination was made of the claims practices and procedures in California of:

Life Insurance Company of North America

NAIC # 65498

Hereinafter referred to as LINA or the Company.

This report is made available for public inspection and is published on the California Department of Insurance web site (www.insurance.ca.gov) pursuant to California Insurance Code section 12938.

SCOPE OF THE EXAMINATION

The examination covered the claims handling practices of the aforementioned Company during the period February 1, 2005 through June 20, 2006. The examination was made to discover, in general, if these and other operating procedures of the Company conform with the contractual obligations in the policy forms, to provisions of the California Insurance Code (CIC), the California Code of Regulations (CCR) and case law. This report contains only alleged violations of Section 790.03 and Title 10, California Code of Regulations, Section 2695 et al. The alleged violations of other relevant laws which resulted from this examination are included in a separate report which will remain confidential subject to the provisions of CIC Section 735.5.

To accomplish the foregoing, the examination included:

1. A review of the guidelines, procedures, training plans and forms adopted by the Company for use in California including any documentation maintained by the Company in support of positions or interpretations of fair claims settlement practices.

2. A review of the application of such guidelines, procedures, and forms, by means of an examination of claims files and related records.

3. A review of consumer complaints received by the California Department of Insurance in the most recent year prior to the start of the examination.

The examination was conducted at the offices of the Company in Glendale, California.

The report is written in a "report by exception" format. The report does not present a comprehensive overview of the subject insurer's practices. The report contains only a summary of pertinent information about the lines of business examined and details of the non-compliant or problematic activities or results that were discovered during the course of the examination along with the insurer's proposals for correcting the deficiencies. When a violation is discovered that results in an underpayment to the claimant, the insurer corrects the underpayment and the additional amount paid is identified as a recovery in this report. All unacceptable or non-compliant activities may not have been discovered. Failure to identify, comment on or criticize activities does not constitute acceptance of such activities.

Any alleged violations identified in this report and any criticisms of practices have not undergone a formal administrative or judicial process.

CLAIM SAMPLE REVIEWED AND OVERVIEW OF FINDINGS

The examiners reviewed files drawn from the category of Closed Claims for the period February 1, 2005, through January 31, 2006, commonly referred to as the "review period". In addition group long term disability files closed in litigation between November 1, 2004 and June 20, 2006 were reviewed. The examiners reviewed targeted samples of claims closed and denied during these window periods. The examiners reviewed 224 claim files. The examiners cited 57 claim handling violations of the Fair Claims Settlement Practices Regulations and/or California Insurance Code Section 790.03 within the scope of this report. Further details with respect to the files reviewed and alleged violations are provided in the following tables and summaries.

Life Insurance Company of North America			
LINE OF BUSINESS/CATEGORY	**CLAIMS FOR REVIEW PERIOD**	**REVIEWED**	**CITATIONS**
Accident and Disability / Long Term Disability / Group	1,655	159	39
Accident and Disability / Long Term Disability / Group / Suit Filed	139	20	18
Life / Group	196	45	0
TOTALS	**1,990**	**224**	**57**

TABLE OF TOTAL CITATIONS		
Citation	**Description**	**Life Insurance Company of North America**
CIC §790.03(h)(3)	The Company failed to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under its insurance policies.	27
CIC §790.03(h)(5)	The Company failed to effectuate prompt, fair and equitable settlements of claims in which liability had become reasonably clear.	17
CIC §790.03(h)(1)	The Company failed to represent correctly to claimants, pertinent facts or insurance policy provisions relating to a coverage at issue.	6
CIC §790.03(h)(6)	The Company compelled insureds to institute litigation to recover amounts under an insurance policy by offering substantially less than the amounts ultimately recovered in actions brought by the insureds, when the insureds have made claims for amounts reasonably similar to amounts ultimately recovered.	4
CCR §2695.7(g)	The Company attempted to settle a claim by making a settlement offer that was unreasonably low.	2
CCR §2695.7(b)(3)	The Company failed to include a statement in its claim denial that, if the claimant believes the claim has been wrongfully denied or rejected, he or she may have the matter reviewed by the California Department of Insurance	1
Total Citations		**57**

TABLE OF CITATIONS BY LINE OF BUSINESS

ACCIDENT AND DISABILITY	NUMBER OF CITATIONS
CIC §790.03(h)(3)	27
CIC §790.03(h)(5)	17
CIC §790.03(h)(1)	6
CIC §790.03(h)(6)	4
CCR §2695.7(g)	2
CCR §2695.7(b)(3)	1
SUBTOTAL	**57**

LIFE	NUMBER OF CITATIONS
	0
SUBTOTAL	0
TOTAL	**57**

SUMMARY OF RESULTS

The following is a brief summary of the criticisms that were developed during the course of this examination related to the violations alleged in this report. This report contains only alleged violations of Section 790.03 and Title 10, California Code of Regulations, Section 2695 et al. In response to each criticism, the Company is required to identify remedial or corrective action that has been or will be taken to correct the deficiency. Regardless of the remedial actions taken or proposed by the Company, it is the Company's obligation to ensure that compliance is achieved. As referenced in section number five below, money recovered within the scope of this report was $137,289.30. The Company indicates that the corrective actions implemented as a result of this exam were taken in all jurisdictions where applicable.

ACCIDENT AND DISABILITY

1. In 27 instances, the Company failed to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under its insurance policies. The Department alleges these acts are in violation of CIC §790.03(h) (3).

1A. In six instances, the Company applied a 21-day or 45-day deadline for submission of proof of claim after receiving notice of claim on Group Long Term Disability policies. The Company indicated to the claimant that, if all the information necessary to make a benefit determination was not received in 45 days from the date of notice, the Company would review the information, (or lack of information) in the file and make an initial claim decision. The Company routinely required documentation, as a standard for entitlement of benefits, to include loss of work-related functions documented in medical records, office notes, and reports of comprehensive medical assessments. When the claimant could not produce these documents within 45 days, the claim was denied and entered the appeal process. Three of the claimants indicated there were reports relating to comprehensive medical assessments that the claimant had not been able to acquire yet. The other three claimants indicated outstanding medical records would support their claims. The claims were denied for lack of information, prior to the Company obtaining any of the above. An allegedly disabled claimant was required to collect all medical records during the appeal process if the additional records were to be included in the review. There was no policy language or statute to support these deadlines. The Department does acknowledge that Title 29, Chapter XXV Section 2560.503-1 of the United States Labor Code requires an adverse benefit determination to be made within 45 days after proof of claim is received. Section 2560.503-1 specifically allows for additional time and tolls the statute when "information necessary to decide a claim" is to be submitted by the claimant and is unavailable to the administrator. It was unreasonable to deny these claims when the Company was aware that the kind of information it required for potential entitlement of benefits (medical records and medical assessment reports) existed but was not obtained by the Company and reviewed prior to making the denial decision. The 45-day deadline was not supported by policy language, statute or precedent. The Department alleges these acts are in violation of CIC §790.03(h) (3).

Summary of Company Response to 1A: The Company acknowledges these violations. "The Company originally established its claimant response timeframes to ensure compliance with the Company's obligations under CIC §790.03(h) (3) to 'adopt and implement reasonable standards for the *prompt* investigation and processing of claims'. The Company believes that providing claimants with clear and specific timelines for submitting supporting documents aids claimants in obtaining benefits promptly, and that such timelines are not prohibited by CIC §790.03(h)(3). However, the Company acknowledges the Department's concern that in these isolated instances the Company's claims personnel applied these timeframes too rigidly. Accordingly, the Company will update its policies and procedures regarding initial claim evaluations to emphasize that while claims personnel should attempt to resolve the claim within 45 days of receipt of the claim, claims personnel may utilize up to two 30-day extensions (as authorized under ERISA) when the claimant indicates that additional supporting documents are available or are being obtained. Further, the Company's revised policies and procedures will provide that throughout the initial evaluation process, claims personnel will follow up with and provide status updates to the claimant at least every 30 days. The Company will also update the letter template which claim personnel utilize during the initial evaluation process to ensure the Company's written communications clearly express these policies."

1B. In three instances, the Company failed to request medical records prior to making a claim determination. These included instances in which the Company failed to work with the treating physicians in obtaining medical records or failed to request any medical records. The Company limited its request by sending two facsimiles to the medical provider. If the medical provider indicated this was not the way he/she operated, the adjuster requested the medical records directly from the claimant. The Company also failed to send a copy service to collect medical records necessary to decide a claim or otherwise work within parameters acceptable to the attending physician. The Department alleges these acts are in violation of CIC §790.03(h) (3).

Summary of Company Response to 1B: The Company acknowledges these violations. "While the Company's current policies and procedures require claims personnel to make 'meaningful contact' attempts to follow up on all requests for medical records, the Company acknowledges that in these isolated instances claims personnel did not do so. Prior to this examination, consistent with the Company's commitment to support claimants in obtaining proof of disability for the claim file in a timely manner, the Company began and has now completed implementation of the following:

- Entered into a vendor agreement with a copy service provider.
- Partnered with Kaiser Permanente, one of the largest medical treatment providers in California, to maintain a copy of the custom disclosure authorization Kaiser Permanente requires for release of medical information for its patients.
- Implemented a medical records position within each Field Claim Office accountable for requesting medical records on behalf of the claimant during the initial claim evaluation. This employee will utilize phone, fax, and mail

to request necessary information as well as process both pre-payment requests, ongoing follow-up for receipt of information, and any other billing needs.

The Company believes that the completion of the foregoing quality measures will aid in avoiding future issues. However, in addition the Company will provide claims personnel with specific instructions and training to ensure (1) that requests for medical records are pursued, to every extent possible, in a manner consistent with the procedures of the attending physicians, including obtaining the requested information through the use of the phone, fax, mail, or copy service, or by such other reasonable means as may be requested by the treating physician; and (2) that all reasonable attempts to obtain necessary records are exhausted prior to making a determination to deny a claim."

1C. In five instances, the claimants had provided significant documentation relating to potentially disabling conditions, but had not paid for or provided their own functional testing. The files reflect the attending physician treated the claimants but did not perform functional testing. The Company failed to perform any functional testing or peer review of medical records on file while at the same time the Company was utilizing functional test results as the guidepost for medical information necessary to the entitlement of benefits. In addition, the Company asked an attending physician if the attending physician could contact the health insurance carrier of a claimant to arrange and pay for a functional capacity examination. It is unreasonable for the Company to require the claimants to perform their own functional testing to receive benefits. The Department alleges these acts are in violation of CIC §790.03(h) (3).

Summary of Company Response 1C: The Company acknowledges these violations. "The Company's policies and procedures do not expressly or implicitly authorize claims personnel to request a treating physician to arrange for a functional capacity examination (FCE) for a claimant, nor does the Company require a claimant to pay for his or her own FCE. The Company will conduct additional training to emphasize that once the claims personnel determine that an FCE is required for making a determination on a claim, the responsibility for arranging the FCE falls on the Company and the claims personnel, not on the claimant."

1D. In six instances, the Company failed to consult with a health care professional who had appropriate training and experience in the field of medicine involved in the medical judgment. These files reflected Physical Therapists performing functional test or medical records reviews of patients with HIV and co-morbid conditions such as AIDS, diabetes, cardiovascular disease, lypodystrophy, recent heart surgeries and fecal incontinence. In addition, medical records were reviewed by a Company Physical Therapist for claimants with chemotherapy related fatigue and multiple sclerosis. The disabling condition indicated by the attending physician was not addressed. The claim files did not address if the claimant could perform an occupation with reasonable continuity. The Department alleges these acts are in violation of CIC §790.03(h)(3).

Summary of Company Response to 1D: The Company acknowledges these violations. "The Company recognizes that thorough consideration of medical

information for establishing restrictions and limitations is necessary for high quality, accurate claim determinations, and is particularly aware of its obligation to utilize appropriate medical experts that are trained to deal with the particular type of medical issues that arise on a claim. Following the Department's Market Conduct Examination of the Company in 2003, the Company (1) more than doubled the size of its staff of medical directors and nurse case managers; (2) increased the medical resources available to claims personnel to ensure a thorough, fair and medically sophisticated review of claim materials; and (3) assigned medical directors and nurse case managers to staff claim files with claim managers for the purpose of allowing for greater peer-to-peer contact with treating physicians, and to improve the quality and clarity of written narratives for treating physicians. A number of the files cited by the Department were handled *prior* to the complete implementation of these improvements and staffing increases, and the Company is confident that the concerns raised by the Department on such claims would not have occurred if handled with the Company's current staffing and resources. Nonetheless, the Company will conduct additional training of appropriate claims personnel to ensure that they are aware of the specialized medical resources available at the Company to aid in the proper evaluation of complex medical claims, and are aware of their obligation to attempt to 'match' the specialized medical resources to a claimant's potentially disabling medical condition. In addition, the Company will make specific changes to the applicable policy and procedure to remind claims personnel of their obligation to take affirmative steps to clarify functional capacity based upon a review of the claims file as a whole, rather than relying exclusively on statements in formal reports of an FCE or a physical abilities assessment (PAA)."

1E. In two instances, the Company utilized the attending physician statement to support its "not disabled" analysis while not clarifying with the attending physician why he/she was indicating continuing disability. The Company failed to have medical personnel review test results reflecting the existence of a potentially disabling condition that came in after the denial. The Department alleges the above acts are in violation of CIC §790.03(h) (3).

Summary of Company Response to 1E: The Company acknowledges these violations. "The Company recognizes its obligation to administer claims based on a thorough review and analysis of the totality of the available records, and believes that it's Claims Philosophy and claims policies and procedures reflect this obligation. The Company notes that the addition of specialized medical resources now available to claims personnel, as describe[d[above in the Company's responses to Sections 1.B & 1.D, will assist claims personnel in recognizing reconciling potentially conflicting statements from a treating physician within a claim file. The Company will conduct additional training of claims personnel as described above in response to Section 1.D."

1F. In two instances, claims were denied during the "any occupation" period in which the Company failed to perform a transferable skills analysis and labor market survey to identify alternate occupations appropriate to the claimants based on their restrictions, limitations, education, training, and station in life. The Company assumed alternate occupations existed based on Dictionary of Occupational Titles classifications such as

"sedentary" but failed to identify the alternate occupations. The Department alleges these acts are in violation of CIC §790.03(h) (3).

Summary of Company Response to 1F: The Company acknowledges these violations. "The Company agrees that in these two isolated instances the Company's claims personnel did not follow existing policies and procedures which called for a formal and complete transferable skills analysis as part of the 'any occupation' evaluation. While these errors in analysis or file documentation did not result in an incorrect claim determination on either claim, the Company recognizes that full and proper analysis and documentation is essential to accurate claims handling. The Company will conduct further training to reinforce with claims personnel the need for proper documentation of files regarding the conduct of a transferable skills analysis. In addition, the Company refers to its Response to Section 2.B, below, relating to amendments to its guidelines for investigating a claimant's transferable skills during the 'any occupation' period."

1G. In two instances, the adjuster ignored substantial information that came into the file after the initial denial. This included information received over a period of eleven months including signed authorizations; hospital records indicating trauma and coma; completed attending physician statements; and names, addresses and phone numbers of treating specialists. The Department alleges these acts are in violation of CIC §790.03(h) (3).

Summary of Company Response to 1G: The Company acknowledges these violations. "The Company acknowledges the claim management deficiencies identified in these two claim files. The Company immediately reviewed these claims to afford these claimants the level of quality and claim management standards consistent with the Company's standards. The Company has provided the Department with documentation of its remedial actions for these claimants."

1H. In one instance, the Company failed to investigate the course and nature of the disabling condition as it related to the first date missed from work and the end of the waiting period. The Department alleges this act is in violation of CIC §790.03(h) (3).

Summary of Company Response to 1H : The Company acknowledges this violation. "The Company recognizes its obligation to carefully administer claims arising from disability caused by ongoing medical conditions, to ensure that the entire course and nature of the condition is considered when assessing a claimant's entitlement to benefits. The Company has prepared and will release promptly to its claims personnel a new policy and procedure that specifically articulates practices designed to ensure that the full course and nature of an ongoing medical condition is thoroughly and fairly evaluated."

Summary of Company General Responses to Section 1: "The Company is committed to providing prompt, accurate and supportive claim administration for our customers. We train our claims representatives continuously and every claims representative is required to sign a certification that they understand and adhere to the following Claim Philosophy:

- Pay all covered claims and fulfill our contractual and fiduciary responsibilities
- Treat our customers and claimants as we would want to be treated
- Act with integrity, objectivity and a sense of urgency in the evaluation of claims
- Assist our employer customers and their disabled employees in the shared goal of returning to productive work.

Our policies and procedures are designed to implement this philosophy in strict compliance with California law. While inevitably mistakes will be made, our claims administration largely reflects our philosophy of providing high quality and accurate service to our claimants.

The Company has acknowledged each of the Department's cited violations, even in those situations in which the Company believes that the handling of the claim was consistent with California law and the Company's policies and procedures. In many of the instances cited by the Department, the Company had undertaken corrective steps on the claim prior to or during the course of the Department's examination. On the whole, the Company believes that the cited files reflect isolated instances of failure to diligently follow the Company's policies and procedures that are not indicative of the Company's normal claims processing standards, and thus do not represent a general business practice in violation of CIC §790.03(h)(3).

However, in order to further address the Department's concerns, the Company will re-emphasize the importance of proper claims handling and continue to audit to ensure prompt and reasonable investigations and timely benefits payments. As indicated above, the Company will clarify language in several existing policy statements and letter templates, release new policy and procedures, institute process improvements for requesting and obtaining necessary information for the claim file, and reinforce the obligation of claims personnel to adhere to the Company's existing best practices."

2. <u>In 17 instances, the Company failed to effectuate prompt, fair and equitable settlements of claims in which liability had become reasonably clear.</u> The Department alleges these are violations of CIC §790.03(h) (5).

2A. In two instances, the Company denied claims during the "any occupation" period but failed to perform transferable skills analysis or Labor Market Survey to identify alternate occupations that the claimants could reasonably perform given their restrictions, limitations, education, training and station in life.

<u>Summary of Company Response to 2A:</u> The Company acknowledges these violations. "The Company agrees that in these two isolated instances the Company's claims personnel did not follow existing policies and procedures which called for a formal and complete transferable skills analysis as part of the 'any occupation' evaluation. While these errors in analysis or file documentation did not result in an incorrect claim determination on either claim, the Company recognizes that full and

proper analysis and documentation is essential to accurate claims handling. The Company will conduct further training to reinforce with claims personnel the need for proper documentation of files regarding the conduct of a transferable skills analysis. In addition, the Company refers to its Response to Section 2.B, below, relating to amendments to its guidelines for investigating a claimant's transferable skills during the 'any occupation' period."

2B. In one instance, the Company assumed that alternate employers could make an accommodation for the claimant but never provided supporting documentation for this. The Department alleges this act is in violation of CIC §790.03(h) (5).

Summary of Company Response to 2B: The Company acknowledges this violation. "The Company's existing policies and procedures require direct contacts with employers and employees to obtain complete information necessary to the assessment of the claimant's ability to perform the requirements of the claimant's own occupation. Once the actual requirements of the occupation are established, the Company notes that under California law the Company's claim determination must be made based on the existence of 'factual disability' (i.e., the factual inability to perform the actual requirements of the occupation), and the fact that the claimant's employer may be unwilling or unable to allow the claimant to resume his or her 'own job' does not constitute a factual disability on which benefits must be paid. *See Bendixen v. Standard Ins. Co.* 185 F. 3d 939, 944 (9th Cir. 1999) (claimant's inability to resume own job with employer does not constitute disability when the medical evidence shows that she was able to perform her own occupation for other employers); *see also, Goomar v. Centennial Life Ins. Co.,* 855 F.Supp. 319, 325 (S.D.Cal.1994) ('It is a general rule that disability insurance policies ... provide coverage for factual disabilities (i.e., disabilities due to a sickness or injury) and not for legal disabilities.'). With respect to this claim, the Company determined that there was no 'factual disability' as the claimant could in fact perform all the requirements of her own occupation. The Department's citation alleges that the Company should have taken additional steps to rule out the possible existence of a 'legal disability' (i.e., a potential industry-wide refusal to hire a person with the claimant's specific medical history), and to locate specific employers who would be factually willing to employ the claimant. While the Company believes that the Department's position is contrary to California law, in order to ensure its compliance with the Department's view of California law, the Company will begin to develop revisions to its policies and procedures to provide additional guidance to claims personnel on appropriate investigatory steps during occupation evaluations for California claimants."

2C. In two instances, the Company applied a 60% threshold to the relation of the wages of alternate occupations to the claimant's pre-disability earnings. The 60% was not supported contractually or by California precedent. The file did not reflect a "station in life" rationale or consideration. The Department alleges these acts are in violation of CIC §790.03(h) (5).

Summary of Company Response to 2C: The Company acknowledges these violations. "The Company recognizes its obligation in California to consider a claimant's 'station in life' when conducting an evaluation of potential alternate occupations for the claimant. While the Company generally believes that its policies and procedures comply with California law in this regard, it recognizes the Department's concern and will amend its policies and procedures to more specifically emphasize the need to take into account the claimant's individual 'station in life' during the evaluation of alternative occupations."

2D. In two instances, the Company applied a "national economy" definition during the own occupation on claims in which the claimants could not perform their own occupations. The Company identified alternate occupations in the national economy the claimant allegedly could perform while the file reflected the claimant could not perform the occupation they were performing prior to becoming disabled. The files reflect that the claimants were unable to perform with reasonable continuity the substantial and material acts necessary to pursue their usual occupations in the usual and customary way. The Department alleges these acts are in violation of CIC §790.03(h) (5).

Summary of Company Response to 2D: The Company acknowledges these violations. "The Company recognizes its obligation to evaluate claims during the 'own occupation' period based on the claimant's ability to perform the actual responsibilities of the claimant's specific occupation, notwithstanding policy language that refers to job requirements in the 'national economy'. The Company will reintroduce and provide training to claims personnel on its existing policy and procedure that specifically addresses this issue."

2E. In three instances, the Company failed to consider the course and nature of an illness prior to denial of benefits. The Company identified objective tests results indicating disability once the claimant was properly tested by the proper medical professional. However, as this objective testing did not take place within the waiting period, the claim was denied as the claimant was no longer covered under the policy when disability was documented by subjective test results. The Company failed to ask reasonable and specific questions of the attending physicians and the Company health care professionals as to the course and nature of illnesses such as HIV/AIDS and degenerative disc disease. Claimants receiving conservative treatment initially and going to a specialist only after the end of the waiting period were not given consideration of the nature and course of their disabling condition prior to the denial of the claim. The Department alleges these acts are in violation of CIC §790.03(h) (5).

Summary of Company Response to 2E: The Company acknowledges these violations. "As discussed in the Company's Response to Section 1.H, the Company has drafted a policy on the evaluation of medical information in accordance with the course and nature of an ongoing medical condition."

2F. In one instance each, the Company adjuster:

2F(1). Ignored the medical assessment by LINA's own medical health professional that the claimant was disabled and denied additional benefits. The Department alleges this act is in violation of CIC §790.03(h) (5).

Summary of Company Response2F (1): The Company acknowledges this violation. "The Company will conduct training sessions to emphasize the importance of reviewing all documents on file and considering the claim as a whole prior to making a claim determination. Training sessions will also provide guidance on reconciling potentially conflicting views and will reinforce the importance of documenting the rationale for a claim determination in the file and in communications to the claimant."

2F(2). Removed several disabling health conditions (HIV, heart disease, wasting disease) from the claimant's medical history on file prior to requesting an internal health care professional to review and sign-off as to whether the claimant was disabled. None of the claimed disabling conditions were addressed in the assessment summary of the LINA nurse consultant. The Department alleges this act is in violation of CIC §790.03(h) (5).

Summary of Company Response to 2F (2): The Company acknowledges this violation. "The Company carefully reviewed this claim and believes that the file does not demonstrate any intent on the part of claims personnel to manipulate the outcome of the health care professional's file review, but rather was an attempt to avoid asking the professional to review materials that had already been reviewed. The Company acknowledges that the process followed by claims personnel in this isolated instance created some risk that the nurse consultant might inadvertently fail to consider or reconsider materials that had been previously provided and reviewed. Accordingly, the Company has counseled the claims manager and provided instructions not to utilize this process to prepare follow-up staffing requests in the future, and to accurately document all such staffing requests in the file."

2F(3). Ignored correspondence received after the initial denial that reasonably required a response. The Department alleges this act is in violation of CIC §790.03(h) (5).

Summary of Company Response to 2F (3): "The Company has acknowledged this isolated occurrence and immediately worked to correct the problem and handle the claim in line with established quality standards."

2F (4). Failed to clarify the claimant's restrictions and limitations with the attending physician who was indicating the claimant was disabled. The Department alleges this act is in violation of CIC §790.03(h) (5).

Summary of Company Response to 2F (4): The Company acknowledges this violation. "The Company's current policies and procedures

provide detailed guidance to claims personnel on the need to resolve discrepancies in medical statements or conclusions within a file, including recommendation to use peer-to-peer contact with treating physicians to help reconcile such conflicts. In this isolated instance, the file does not clearly indicate whether or not the Company's procedures were followed. Accordingly, the Company will counsel and retrain the claims manager on the applicable policy and procedure, and will stress the importance of fully documenting such activity in the file."

2F (5). Failed to provide complete information in the file to the health care expert performing a peer review of the medical records.

Summary of Company Response to 2F (5): The Company acknowledges this violation. "The Company carefully reviewed this claim and believes that the file does not demonstrate any intent on the part of the claims manager to provide incomplete information to the health care expert performing peer review. However, the Company will counsel and retrain the claims manager on the Company's applicable policy and procedure, and will emphasize the need to provide peer reviewers with all available information, and to accurately document in the file that this has occurred."

2F (6). Misapplied the Mental and Nervous two-year policy coverage limitation when the file reflected a physiological condition contributed to the disabling condition. The Department alleges this act is in violation of CIC §790.03(h) (5).

Summary of Company Response to 2F(6): "The Company has acknowledged this isolated occurrence and will reinforce appropriate applications of the Company's relevant policies and procedures by providing additional training to appropriate claims personnel."

2F (7). Failed to investigate how the claimant could perform his/her own occupation given the restrictions applied. The file failed to contain supporting documentation that the claimant could reasonably and safely perform the occupation given his/her medical condition and history of passing out unexpectedly. The Department alleges this act is in violation of CIC §790.03(h) (5).

Summary of Company Response to 2F (7): "The company acknowledges this violation and notes that the Company's current policies and procedures provide for the Company to conduct a full investigation of the requirements of the claimant's specific occupation to determine claimant's physical ability to perform his/her own occupation. For this claim, the condition was self reported by the claimant, and the Company determined that a loss of functional capacity was not indicated by medical evidence. However, the Company agrees with the Department that once functional capacity is established, the claim manager would be and is required to conduct a full evaluation of the

facts to determine if the claimant was physically able to perform his/her occupation. The Company will review existing procedures with this claim manager to ensure understanding of these requirements. "

Summary of Company General Responses to Section 2: "The Company has acknowledged each of the Department's cited violations, even in those situations in which the Company believes that the handling of the claim was consistent with California law and the Company's policies and procedures. In several instances cited by the Department, the Company had undertaken self-corrective steps on the claim prior to or during the course of the Department's examination. On the whole, the Company believes that the cited files reflect isolated instances of failure to follow diligently the Company's policies and procedures that are not indicative of the Company's normal claims processing standards, and thus do not represent a general business practice in violation of CIC § 790.03(h)(5).

However, in order to further address the Department's concerns, the Company will re-emphasize the importance of proper claims handling and continue to audit to ensure prompt and reasonable investigations and timely benefits payments. As indicated above, the Company will clarify language in several existing policy statements and letter templates, release new policy and procedures, institute process improvements for requesting and obtaining necessary information for the claim file, and reinforce the obligation of claims personnel to adhere to the Company's existing best practices."

3. In six instances the Company failed to represent correctly to claimants, pertinent facts or insurance policy provisions relating to a coverage at issue. The Department alleges these acts are violations of CIC §790.03(h) (1).

3A. Three of these instances reflected claims involving government entities. The claimant was sent a denial letter indicating the claim was covered by ERISA (Employee Retirement Income Security Act of 1974). The adjuster did not contact the government entity to determine if they were an exception to the rule regarding government entities not being subject to ERISA. The Department alleges these acts are in violation of CIC §790.03(h) (1).

Summary of Company Response to 3A: The Company acknowledges these violations. "In the ordinary course of the Company's business, the Company is required to rely upon the insured employers to accurately indicate whether or not the employer's benefit plan is covered under ERISA. When a policy is issued, Company personnel outside of the Claims Department enter the ERISA status of the employer's benefits plans into the Company's computer system. Thereafter, the Claims Department must rely on that information as accurately indicating the employer's position on whether the plan is or is not an ERISA covered plan. Claims personnel rely on this information in determining the correct and accurate language to utilize in correspondence with the claimant. The Company acknowledges that in four of the six cited files, claims personnel erred and inadvertently used letter templates that did not match the ERISA status of the benefit plan in which the claimant was a participant. In two instances, however, claims personnel accurately used letter templates that correctly reflected the indication of the employer as to the ERISA status of employers' plans. The Company does not believe

that reliance by claims personnel on information provided by the employer during the implementation of the account supports a violation of CIC § 790.03(h) (1). Nonetheless, given that inadvertent errors did occur on 4 of the 6 cited files, and in order to recognize the Department's expectation that the Company will in certain circumstances re-confirm an employer's statements as to the ERISA status of its plan, the Company will (1) reinforce with claims personnel its policies and procedures regarding the use of appropriate letter templates based on the ERISA status of the applicable benefit plan; and (2) refer this Examination Report to its Policy Implementation Department to assess the possible formulation of quality measures to ensure that the ERISA status of the employers' plan is accurately entered on the Company's system at implementation."

3B. In one instance, the Company misrepresented to the claimant the Mental and Nervous policy limitation as it is to be applied in California. The correspondence indicated the claimant would have to demonstrate that they remained disabled solely due to a physiological condition to remain on benefit. The adjuster failed to indicate that disabling conditions caused by, contributed to or concurrent with a psychological condition would not be applicable to the two year policy limitation. The Department alleges this act is in violation of CIC §790.03(h) (1).

Summary of Company Response to 3B: "The Company has acknowledged this isolated occurrence and has scheduled in-person training of appropriate claims personnel on the accurate interpretation and application of the Company's Mental & Nervous policy provisions to ensure that the handling of these claims complies in all respects with California law. The Company also notes that following the adjustment of this claim, the Company opened a new claims office in Glendale, California, and has begun transitioning all California claims to that office for handling. This will provide superior service for California claimants from claims personnel who are specifically trained to be familiar with California law."

3C. In one instance, the Life Waiver of Premium was discontinued as the claimant was not "totally disabled". The Company applied a guidepost of any income level on a part-time basis would equate to a claimant not being totally disabled. We could find no support for this in California precedent. The Department alleges this act is in violation of CIC §790.03(h) (1).

Summary of Company Response to 3C: The Company acknowledges this violation. "The Company has reviewed this file, has requested updated medical information on the claimant, and will reinstate claimant's life policy on a waiver of premium status if the file, as updated, indicates that the claimant is unable to work with reasonable continuity and is therefore disabled for purposes of qualifying for the life waiver of premium benefit."

3D. In one instance, the Company sent correspondence to the claimant indicating the policy "requires" them to apply for Social Security Income Disability Insurance. The policy contained no such requirement. The Department alleges this act is in violation of CIC §790.03(h) (1).

Summary of Company Response to 3D: The Company acknowledges this violation. "The Company corrected this isolated error prior to the Examination by sending a letter to the claimant which provided an accurate explanation of the contract language. This was an isolated and unintentional error that is not indicative of the Company's normal processing standards."

Summary of Company General Responses to Section 3: "The Company has acknowledged each of the Department's cited violations, even in those situations in which the Company believes that the handling of the claim was consistent with California law and the Company's policies and procedures. In several instances cited by the Department, the Company had undertaken self-corrective steps on the claim prior to or during the course of the Department's examination. On the whole, the Company believes that the cited files reflect isolated instances of failure to follow diligently the Company's policies and procedures that are not indicative of the Company's normal claims processing standards, and thus do not represent a general business practice in violation of CIC § 790.03(h)(1).

However, in order to further address the Department's concerns, the Company will take the specific steps described above in order to re-emphasize the importance of proper claims handling to ensure prompt and reasonable investigations and timely benefits payments consistent with the Company's existing best practices."

4. In four instances, the Company compelled insureds to institute litigation to recover amounts under an insurance policy offering substantially less than the amounts ultimately recovered in actions brought by the insureds, when the insureds have made, claims for amounts reasonably similar to amounts ultimately recovered. The Department alleges these acts are in violation of CIC §790.03(h) (6).

All of these files reflected that the Company had failed to perform a proper investigation of the claim or had misapplied policy provisions. These errors were recognized only after the claimant had instituted litigation as follows:

4A. In one instance, the Company misapplied the two year Mental and Nervous Limitation to include disabilities contributed to by a physiological component.

Summary of Company Response to 4A: The Company acknowledges this violation. "The Company corrected this isolated error prior to the Examination and without regard to the litigation."

4B. In one instance, the Company failed to address the course and nature of the disabling condition in relation to the date of disability and waiting period.

Summary of Company Response to 4B: The Company acknowledges this violation. "The Company has created a new policy and procedure release regarding 'course and nature.' This release will provide guidance to claims staff on how much consideration to give to a claimant's total situation when a specific disabling event is not presented, but rather the claim is filed as the result of an ongoing medical condition for

which the claimant has been receiving treatment, and certification of disability as of the last date worked may not be readily apparent."

4C. In one instance, the Company applied a 60% threshold of earnings from the alternate occupation in relation to the pre-disability earnings. The file contained no reference to the claimant's "station in life."

Summary of Company Response to 4C: The Company acknowledges this violation "The Company notes that the claimant chose to forego any rights to an appeal she had under ERISA and instead filed suit. A member of the appeal team was ultimately able to conduct a review of the entire claim file, and made the determination to reinstate benefits. As noted in the Company's response in Section 2.B above, the Company acknowledges its obligation to consider the claimant's 'station in life' when applying the 60% wage threshold. The Company believes that its policies and procedures, as revised, will comply with California law."

4D. In one instance, the Company failed to investigate how the claimant could perform the alternate occupation with limited use of her hands.

Summary of Company Response to 4D: The Company acknowledges this violation. "The Company notes that the claimant chose to forego any right to an appeal she had under ERISA and instead filed suit. If the claimant had gone forward with the appeals process, in line with the Company's policies and procedures, the appeals team would have reviewed the new information, reopened the claim, and reinstated benefits. However, the Company will counsel the appropriate claims managers to ensure that claims are handled in a manner fully consistent with the Company's established claims practices in order to eliminate or reduce the risk that claimants will be required to utilize ERISA appeal remedies or litigation to obtain benefits."

Summary of Company General Responses to Section 4: "The Company has acknowledged each of the Department's cited violations, even in those situations in which the Company believes that the handling of the claim was consistent with California law and the Company's policies and procedures. In several instances cited by the Department, the Company had undertaken self-corrective steps on the claim prior to or during the course of the Department's examination. On the whole, the Company believes that the cited files reflect isolated instances of failure to follow diligently the Company's policies and procedures that are not indicative of the Company's normal claims processing standards, and thus do not constitute a general business practice of requiring claimants to commence litigation in order to obtain benefits.

However, in order to further address the Department's concerns, the Company has recently implemented senior claim manager review and sign-off of all adverse claim determinations. The Company has also reduced these senior claim managers' claim loads to ensure they have time to focus on these additional reviews. Additionally, the Company will make efforts to calibrate the senior claim manager staff based on feedback from internal audit reviews. Team Leaders at the Company will review findings from audit reviews and track areas requiring increased focus.

Based on findings, the Company will propose training, policy and procedures, or performance management as necessary to ensure consistent compliance with California law."

5. In two instances, the Company attempted to settle a claim by making a settlement offer that was unreasonably low. In one instance, the Company failed to include an additional 10% to the monthly benefit as the policy allowed an additional 10% when income from other income was offset. The other instance reflected a period of disability during which a two year Mental and Nervous limitation was applied to a period of disability contributed to by a physiological condition. The amount recovered for consumers on these two claims was $137, 289.30. The Department alleges these acts are in violation of CCR §2695.7(g).

Summary of Company Response to 5: The Company acknowledges this violation. "The Company believes these are isolated and inadvertent errors and not indicative of its normal processing standards. In both situations, the errors were rectified as soon as they were discovered and the additional benefits were paid. As indicated in Section 3, the Company has scheduled specific training to emphasize the importance of proper claim handling in line with existing policies and procedures on the topic of concurrent physical and mental conditions. The Company's in-house claim counsel will train personnel in the California claims office on polices and procedures that were established in light of *Patterson v. Hughes*. The Company will also continue to audit to ensure that proper benefit payments are made."

6. In one instance, the Company failed to include a statement in its claim denial that, if the claimant believes the claim has been wrongfully denied or rejected, he or she may have the matter reviewed by the California Department of Insurance. The Department identified one instance, only in which the Company failed to include the California Department of Insurance language on a denial letter. The Department alleges this act is in violation of CCR §2695.7(b) (3).

Summary of Company Response to 6: "The Company acknowledges this isolated error. The Company has since instituted a letter generation system to facilitate content accuracy. The system now prompts claims personnel to verify the need for California Department of Insurance language in adverse decision letters."

LIFE

There were no citations alleged or criticisms of insurer practices in this line of business within the scope of this report.